*Confidential Client Intake Form*

Name:_____ Phone Number:_____

Email Address(for specials and promotions):_____

City: _____ State:_____ Birthday: _____

Have you been here before? _____ Referred by:_____

If taking medications, what is the condition you take it for? _____

**Please indicate any of the following conditions that you may have:**

| | | | |
|---|---|---|---|
| __diabetes | __back pain | __skin sensitivity | __neck pain |
| __osteoporosis | __headaches | __numbness | __tingling |
| __high blood pressure | __low blood pressure | __dizziness | __joint swelling |
| __neck injury | __recent surgery | __arthritis | __skin condition |
| __open wounds | __contagious disease | __varicose veins | __warts |
| __cardiac problems | __digestion problems | __do you bruise easily | __other pain |
| __hot most of time | __cold most of time | __cold hands and feet | __shoulder pain |
| __lymphatic condition | __pregnant ___weeks | __ breast feeding ___ how long? | |

Allergies(list)_____

**Please Choose your Complimentary Aromatherapy (please select one):**

| | | |
|---|---|---|
| __ Lavender: relaxing | __Rose: calming | __Smiles for Miles (citrus blend) |
| __Eucalyptus: refreshing | __Peppermint : stimulating | __Clear the Air (fresh mint blend) |
| __Lemongrass: revitalizing | __Unscented | __Peace & Harmony (minty, floral blend) |
| __Lavender & Tea tree oil: renewing | __ Cedarwood | |

**Preferred Pressure(circle): Light Medium Deep-$15 Sports-$15**

**Areas to Avoid**(i.e. Scalp, Feet, Left Shoulder)_____

## Add-on Options (these options will not change the length of your appointment):

___ Add Triple Strength CBD Pain Relief - $8
___ Peppermint Scalp Massage - $10
___ Hand or Foot Paraffin - $15 for one or $25 for both (please circle one or both)
___ Hand or Foot Scrub - $10 for one or $15 for both (please circle one or both)

Have you had massage or spa treatments before?_____

Please let us know at any time if you are uncomfortable with the pressure of the massage or temperature of the room. I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment:

Signature:_____Date:_____